

1 EDMUND G. BROWN JR.
Attorney General of California
2 ARTHUR D. TAGGART
Supervising Deputy Attorney General
3 BRIAN S. TURNER
Deputy Attorney General
4 State Bar No. 108991
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 445-0603
Facsimile: (916) 327-8643
7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In In the Matter of the Accusation Against:

Case No. 2011-776

12 **CLARA C. WILLIAMS**
1114 Oakleaf Drive
13 Savannah, GA 31410
14 Registered Nurse License No. 673563

DEFAULT DECISION AND ORDER

15 Respondent. [Gov. Code, §11520]

16
17 **FINDINGS OF FACT**

18 1. On or about March 16, 2011, Complainant Louise R. Bailey, M.Ed., RN, in her
19 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
20 Consumer Affairs, filed Accusation No. 2011-776 against Clara C. Williams (Respondent) before
21 the Board of Registered Nursing (Board). (Accusation attached as Exhibit A.)

22 2. On or about February 14, 2006, the Board issued Registered Nurse License No.
23 673563 to Respondent. The Registered Nurse License was in full force and effect at all times
24 relevant to the charges brought herein and will expire on June 30, 2011, unless renewed.

25 3. On or about March 16, 2011, Respondent was served by certified and first class mail
26 with copies of the Accusation No. 2011-776, Statement to Respondent, Request for Discovery,
27 Notices of Defense and copies of Government Code sections concerning discovery at
28

1 Respondent's address of record which, pursuant to California Code of Regulations, title 16,
2 section 1409.1, is required to be reported and maintained with the Board, which was and is:
3 1114 Oakleaf Drive, Savannah, Georgia 31410.

4 4. Service of the Accusation was effective as a matter of law under the provisions of
5 Government Code section 11505, subdivision (c) and/or Business & Professions Code section
6 124.

7 5. On or about March 28, 2011, the aforementioned documents were returned by the
8 U.S. Postal Service marked address vacant. The address on the documents was the same as the
9 address on file with the Board. Respondent failed to maintain an updated address with the Board
10 and the Board has made attempts to serve the Respondent at the address on file. Respondent has
11 not made herself available for service and therefore, has not availed herself of her right to file a
12 notice of defense and appear at hearing.

13 6. Government Code section 11506 states, in pertinent part:

14 (c) The respondent shall be entitled to a hearing on the merits if the respondent
15 files a notice of defense, and the notice shall be deemed a specific denial of all parts
16 of the accusation not expressly admitted. Failure to file a notice of defense shall
constitute a waiver of respondent's right to a hearing, but the agency in its discretion
may nevertheless grant a hearing.

17 7. Respondent failed to file a Notice of Defense within 15 days after service upon her of
18 the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2011-
19 776.

20 8. California Government Code section 11520 states, in pertinent part:

21 (a) If the respondent either fails to file a notice of defense or to appear at the
22 hearing, the agency may take action based upon the respondent's express admissions
23 or upon other evidence and affidavits may be used as evidence without any notice to
respondent.

24 9. Pursuant to its authority under Government Code section 11520, the Board finds
25 Respondent is in default. The Board will take action without further hearing and, based on the
26 relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as
27 taking official notice of all the investigatory reports, exhibits and statements contained therein on
28 file at the Board's offices regarding the allegations contained in Accusation No. 2011-776, finds

1 that the charges and allegations in Accusation No. 2011-776, are separately and severally, found
2 to be true and correct by clear and convincing evidence.

3 10. Taking official notice of its own internal records, pursuant to Business and
4 Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation
5 and Enforcement is \$7,825.00 as of April 15, 2011.

6 **DETERMINATION OF ISSUES**

7 1. Based on the foregoing findings of fact, Respondent Clara C. Williams has subjected
8 her Registered Nurse License No. 673563 to discipline.

9 2. The agency has jurisdiction to adjudicate this case by default.

10 3. The Board of Registered Nursing is authorized to revoke Respondent's Registered
11 Nurse License based upon the following violations alleged in the Accusation which are supported
12 by the evidence contained in the Default Decision Evidence Packet in this case.:

13 a. Obtain and Possess Controlled Substances In Violation of Law constituting
14 Unprofessional Conduct as set forth in Business and Professions Code section 2762(a)

15 b. Falsify or Make Grossly Incorrect Entries in Patient/Hospital Records constituting
16 Unprofessional Conduct as set forth in Business and Professions Code section 2762(e)

17 ///

18 ///

19 ///

20 ///

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

28 ///

ORDER

IT IS ORDERED that Registered Nurse License No. 673563, heretofore issued to Respondent Clara C. Williams, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 8, 2011.

It is so ORDERED June 10, 2011.

Jeannine K. Reeves

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

default decision_LIC.rtf
DOJ Matter ID:SA2010102480

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

1 EDMUND G. BROWN JR.
Attorney General of California
2 ARTHUR D. TAGGART
Supervising Deputy Attorney General
3 BRIAN S. TURNER
Deputy Attorney General
4 State Bar No. 108991
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 445-0603
Facsimile: (916) 327-8643
7 *Attorneys for Complainant*

8
9 **BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

10
11 In the Matter of the Accusation Against:

Case No. **2011-776**

12 **CLARA C. WILLIAMS**
1114 Oakleaf Drive
13 Savannah, GA 31410
Registered Nurse License No. 673563

A C C U S A T I O N

14 Respondent.
15

16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
19 official capacity as the Executive Officer of the Board of Registered Nursing ("Board"),
20 Department of Consumer Affairs.

21 **Registered Nurse License**

22 2. On or about February 14, 2006, the Board issued Registered Nurse License Number
23 673563 to Clara C. Williams ("Respondent"). The registered nurse license was in full force and
24 effect at all times relevant to the charges brought herein and will expire on June 30, 2011, unless
25 renewed.

26 **STATUTORY PROVISIONS**

27 3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent
28 part, that the Board may discipline any licensee, including a licensee holding a temporary or an

1 inactive license, for any reason provided in Article 3 (commencing with section 2750) of the
2 Nursing Practice Act.

3 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not
4 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or
5 to render a decision imposing discipline on the license. Under Code section 2811, subdivision
6 (b), the Board may renew an expired license at any time within eight years after the expiration.

7 5. Code section 2761 states, in pertinent part:

8 The board may take disciplinary action against a certified or licensed
9 nurse or deny an application for a certificate or license for any of the following:

10 (a) Unprofessional conduct.....

11 6. Code section 2762 states, in pertinent part:

12 In addition to other acts constituting unprofessional conduct within the
13 meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a
14 person licensed under this chapter to do any of the following:

15 (a) Obtain or possess in violation of law, or prescribe, or except as
16 directed by a licensed physician and surgeon, dentist, or podiatrist administer to
17 himself or herself, or furnish or administer to another, any controlled substance as
18 defined in Division 10 (commencing with Section 11000) of the Health and Safety
19 Code or any dangerous drug or dangerous device as defined in Section 4022.

20 (e) Falsify, or make grossly incorrect, grossly inconsistent, or
21 unintelligible entries in any hospital, patient, or other record pertaining to the
22 substances described in subdivision (a) of this section.

23 COST RECOVERY

24 7. Code section 125.3 provides, in pertinent part, that the Board may request the
25 administrative law judge to direct a licentiate found to have committed a violation or violations of
26 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
27 enforcement of the case.

28 8. **CONTROLLED SUBSTANCES**

"Morphine" is a Schedule II controlled substance pursuant to Health and Safety Code
section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Code section 4022, in
that under federal and state law it requires a prescription.

1 "Percocet" is a brand of oxycodone and is a Schedule II controlled substance pursuant to
2 Health and Safety Code section 11055, subdivision (b)(N), and a dangerous drug pursuant to
3 Business and Professions Code section 4022, in that under federal and state law it requires a
4 prescription.

5 "Promethazine" is a Schedule V controlled substance pursuant to Health and Safety Code
6 section 11058, and a dangerous drug pursuant to Code section 4022, in that under federal and
7 state law it requires a prescription.

8 "Tylenol #3" is a Schedule III controlled substance pursuant to Health and Safety Code
9 section 11056, subdivision (e)(2), and a dangerous drug pursuant to Code section 4022, in that
10 under federal and state law it requires a prescription.

11 "Vicodin" is a brand of hydrocodone and is a Schedule III controlled substance pursuant to
12 Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Code
13 section 4022, in that under federal and state law it requires a prescription.

14 FIRST CAUSE FOR DISCIPLINE

15 (Obtain and Possess Controlled Substances in Violation of Law)

16 9. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on
17 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that
18 between February 20, 2008, and March 2, 2008, while on duty as a registered nurse at Coalinga
19 Regional Medical Center, Coalinga, California, Respondent committed the following acts:

20 a. Respondent obtained the controlled substances Morphine, Percocet, Promethazine,
21 Tylenol 3, and Vicodin, by fraud, deceit, misrepresentation, or subterfuge by taking the drugs
22 from hospital supplies in violation of Health and Safety Code section 11173, subdivision (a).

23 b. Respondent possessed the controlled substances Morphine, Percocet, Promethazine,
24 Tylenol 3, and Vicodin, without lawful authority in violation of Code section 4022.

25 SECOND CAUSE FOR DISCIPLINE

26 (Falsify, or Make Grossly Incorrect Entries in Patient/Hospital Records)

27 10. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on
28 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that

1 between February 20, 2008, and March 2, 2008, while on duty as a registered nurse at Coalinga
2 Regional Medical Center, Coalinga, California, Respondent falsified, made grossly incorrect,
3 grossly inconsistent, or unintelligible entries in the following patient/hospital records:

4 **Patient A**

5 a. On February 22, 2008, at 0806 hours, Respondent withdrew 1 Vicodin APAP tablet
6 from the Pyxis system for this patient; however, Respondent failed to document the
7 administration of any portion of the Vicodin in the patient's medication administration record or
8 otherwise account for the disposition of the drug in any hospital record.

9 b. On February 22, 2008, at 1259 hours, Respondent withdrew 1 Vicodin APAP tablet
10 from the Pyxis system for this patient; however, Respondent failed to document the
11 administration of any portion of the Vicodin in the patient's medication administration record or
12 otherwise account for the disposition of the drug in any hospital record.

13 c. On February 22, 2008, at 1308 hours, Respondent withdrew 2 Promethazine
14 w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to
15 document the administration of any portion of the Promethazine w/codeine in the patient's
16 medication administration record or otherwise account for the disposition of the drug in any
17 hospital record.

18 d. On February 23, 2008, at 1030 hours, Respondent withdrew 1 Vicodin APAP tablet
19 from the Pyxis system for this patient; however, Respondent failed to document the
20 administration of any portion of the Vicodin in the patient's medication administration record or
21 otherwise account for the disposition of the drug in any hospital record.

22 e. On February 23, 2008, at 1404 hours, Respondent withdrew 2 Vicodin APAP tablets
23 from the Pyxis system for this patient; however, Respondent failed to document the
24 administration of any portion of the Vicodin in the patient's medication administration record or
25 otherwise account for the disposition of the drug in any hospital record.

26 f. On February 23, 2008, at 1456 hours, Respondent withdrew 2 Promethazine
27 w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to
28 document the administration of any portion of the Promethazine w/codeine in the patient's

1 medication administration record or otherwise account for the disposition of the drug in any
2 hospital record.

3 g. On February 24, 2008, at 0730 hours, Respondent withdrew 2 Vicodin APAP tablets
4 from the Pyxis system for this patient; however, Respondent failed to document the
5 administration of any portion of the Vicodin in the patient's medication administration record or
6 otherwise account for the disposition of the drug in any hospital record.

7 h. On February 24, 2008, at 0731 hours, Respondent withdrew 2 Promethazine
8 w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to
9 document the administration of any portion of the Promethazine w/codeine in the patient's
10 medication administration record or otherwise account for the disposition of the drug in any
11 hospital record.

12 i. On February 24, 2008, at 1058 hours, Respondent withdrew 2 Vicodin APAP tablets
13 from the Pyxis system for this patient; however, Respondent failed to document the
14 administration of any portion of the Vicodin in the patient's medication administration record or
15 otherwise account for the disposition of the drug in any hospital record.

16 j. On February 24, 2008, at 1240 hours, Respondent withdrew 2 Promethazine
17 w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to
18 document the administration of any portion of the Promethazine w/codeine in the patient's
19 medication administration record or otherwise account for the disposition of the drug in any
20 hospital record.

21 k. On February 24, 2008, at 1520 hours, Respondent withdrew 2 Vicodin APAP tablets
22 from the Pyxis system for this patient; however, Respondent failed to document the
23 administration of any portion of the Vicodin in the patient's medication administration record or
24 otherwise account for the disposition of the drug in any hospital record.

25 l. On February 26, 2008, at 1217 hours, Respondent withdrew 2 Vicodin APAP tablets
26 from the Pyxis system for this patient; however, Respondent failed to document the
27 administration of any portion of the Vicodin in the patient's medication administration record or
28 otherwise account for the disposition of the drug in any hospital record.

1 m. On February 26, 2008, at 1348 hours, Respondent withdrew 2 Vicodin APAP tablets
2 from the Pyxis system for this patient; however, Respondent failed to document the
3 administration of any portion of the Vicodin in the patient's medication administration record or
4 otherwise account for the disposition of the drug in any hospital record.

5 **Patient B**

6 n. On February 29, 2008, at 1843 hours, Respondent withdrew 1 Vicodin APAP tablet
7 from the Pyxis system for this patient; however, Respondent failed to document the
8 administration of any portion of the Vicodin in the patient's medication administration record or
9 otherwise account for the disposition of the drug in any hospital record.

10 **Patient C**

11 o. On February 29, 2008, at 1400 hours, Respondent withdrew 1 Morphine Sulfate
12 2mg/1ml syringe from the Pyxis system for this patient; however, Respondent failed to document
13 the administration of any portion of the Morphine Sulfate in the patient's medication
14 administration record or otherwise account for the disposition of the drug in any hospital record.

15 **Patient D**

16 p. On February 22, 2008, at 1832 hours, Respondent withdrew 2 Tylenol #3 tablets from
17 the Pyxis system for this patient; however, Respondent failed to document the administration of
18 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
19 account for the disposition of the drug in any hospital record.

20 q. On February 23, 2008, at 0733 hours, Respondent withdrew 2 Tylenol #3 tablets from
21 the Pyxis system for this patient; however, Respondent failed to document the administration of
22 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
23 account for the disposition of the drug in any hospital record.

24 r. On February 23, 2008, at 1204 hours, Respondent withdrew 2 Tylenol #3 tablets from
25 the Pyxis system for this patient; however, Respondent failed to document the administration of
26 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
27 account for the disposition of the drug in any hospital record.

1 s. On February 23, 2008, at 1808 hours, Respondent withdrew 2 Tylenol #3 tablets from
2 the Pyxis system for this patient; however, Respondent failed to document the administration of
3 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
4 account for the disposition of the drug in any hospital record.

5 t. On February 24, 2008, at 0928 hours, Respondent withdrew 2 Tylenol #3 tablets from
6 the Pyxis system for this patient; however, Respondent failed to document the administration of
7 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
8 account for the disposition of the drug in any hospital record.

9 u. On February 24, 2008, at 1419 hours, Respondent withdrew 2 Tylenol #3 tablets from
10 the Pyxis system for this patient; however, Respondent failed to document the administration of
11 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
12 account for the disposition of the drug in any hospital record.

13 v. On February 24, 2008, at 1827 hours, Respondent withdrew 2 Tylenol #3 tablets from
14 the Pyxis system for this patient; however, Respondent failed to document the administration of
15 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
16 account for the disposition of the drug in any hospital record.

17 w. On February 26, 2008, at 0743 hours, Respondent withdrew 2 Tylenol #3 tablets from
18 the Pyxis system for this patient; however, Respondent failed to document the administration of
19 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
20 account for the disposition of the drug in any hospital record.

21 x. On February 26, 2008, at 1101 hours, Respondent withdrew 2 Tylenol #3 tablets from
22 the Pyxis system for this patient; however, Respondent failed to document the administration of
23 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
24 account for the disposition of the drug in any hospital record.

25 y. On February 26, 2008, at 1157 hours, Respondent withdrew 2 Tylenol #3 tablets from
26 the Pyxis system for this patient; however, Respondent failed to document the administration of
27 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
28 account for the disposition of the drug in any hospital record.

1 **Patient E**

2 z. On February 26, 2008, at 0912 hours, Respondent withdrew 2 Vicodin APAP tablets
3 from the Pyxis system for this patient; however, Respondent failed to document the
4 administration of any portion of the Vicodin in the patient's medication administration record or
5 otherwise account for the disposition of the drug in any hospital record.

6 **Patient F**

7 aa. On February 20, 2008, at 1443 hours, Respondent withdrew 2 Percocet tablets from
8 the Pyxis system for this patient; however, Respondent failed to document the administration of
9 any portion of the Percocet in the patient's medication administration record or otherwise account
10 for the disposition of the drug in any hospital record.

11 **Patient H**

12 bb. On March 1, 2008, at 1019 hours, Respondent withdrew 2 Vicodin APAP tablets
13 from the Pyxis system for this patient; however, Respondent failed to document the
14 administration of any portion of the Vicodin in the patient's medication administration record or
15 otherwise account for the disposition of the drug in any hospital record.

16 cc. On March 1, 2008, at 1733 hours, Respondent withdrew 2 Vicodin APAP tablets
17 from the Pyxis system for this patient; however, Respondent failed to document the
18 administration of any portion of the Vicodin in the patient's medication administration record or
19 otherwise account for the disposition of the drug in any hospital record.

20 dd. On March 2, 2008, at 0740 hours, Respondent withdrew 2 Vicodin APAP tablets
21 from the Pyxis system for this patient; however, Respondent failed to document the
22 administration of any portion of the Vicodin in the patient's medication administration record or
23 otherwise account for the disposition of the drug in any hospital record.

24 ee. On March 2, 2008, at 1108 hours, Respondent withdrew 2 Vicodin APAP tablets
25 from the Pyxis system for this patient; however, Respondent failed to document the
26 administration of any portion of the Vicodin in the patient's medication administration record or
27 otherwise account for the disposition of the drug in any hospital record.

1 **Patient I**

2 ff. On March 1, 2008, at 1146 hours, Respondent withdrew 2 Tylenol #3 tablets from the
3 Pyxis system for this patient; however, Respondent failed to document the administration of any
4 portion of the Tylenol #3 in the patient's medication administration record or otherwise account
5 for the disposition of the drug in any hospital record.

6 gg. On March 1, 2008, at 1732 hours, Respondent withdrew 2 Tylenol #3 tablets from the
7 Pyxis system for this patient; however, Respondent failed to document the administration of any
8 portion of the Tylenol #3 in the patient's medication administration record or otherwise account
9 for the disposition of the drug in any hospital record.

10 **Patient J**

11 hh. On February 29, 2008, at 0745 hours, Respondent withdrew 1 Tylenol #3 tablet from
12 the Pyxis system for this patient; however, Respondent failed to document the administration of
13 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
14 account for the disposition of the drug in any hospital record.

15 ii. On February 29, 2008, at 0953 hours, Respondent withdrew 1 Tylenol #3 tablet from
16 the Pyxis system for this patient; however, Respondent failed to document the administration of
17 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
18 account for the disposition of the drug in any hospital record.

19 jj. On February 29, 2008, at 1149 hours, Respondent withdrew 1 Tylenol #3 tablet from
20 the Pyxis system for this patient; however, Respondent failed to document the administration of
21 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
22 account for the disposition of the drug in any hospital record.

23 kk. On February 29, 2008, at 1149 hours, Respondent withdrew 1 Tylenol #3 tablet from
24 the Pyxis system for this patient; however, Respondent failed to document the administration of
25 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
26 account for the disposition of the drug in any hospital record.

27 ll. On February 29, 2008, at 1358 hours, Respondent withdrew 1 Tylenol #3 tablet from
28 the Pyxis system for this patient; however, Respondent failed to document the administration of

1 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
2 account for the disposition of the drug in any hospital record.

3 mm. On February 29, 2008, at 1358 hours, Respondent withdrew 1 Tylenol #3 tablet from
4 the Pyxis system for this patient; however, Respondent failed to document the administration of
5 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
6 account for the disposition of the drug in any hospital record.

7 nn. On February 29, 2008, at 1524 hours, Respondent withdrew 1 Tylenol #3 tablet from
8 the Pyxis system for this patient; however, Respondent failed to document the administration of
9 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
10 account for the disposition of the drug in any hospital record.

11 oo. On February 29, 2008, at 1745 hours, Respondent withdrew 1 Tylenol #3 tablet from
12 the Pyxis system for this patient; however, Respondent failed to document the administration of
13 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
14 account for the disposition of the drug in any hospital record.

15 pp. On February 29, 2008, at 1746 hours, Respondent withdrew 1 Tylenol #3 tablet from
16 the Pyxis system for this patient; however, Respondent failed to document the administration of
17 any portion of the Tylenol #3 in the patient's medication administration record or otherwise
18 account for the disposition of the drug in any hospital record.

19 qq. On March 1, 2008, at 1001 hours, Respondent withdrew 1 Tylenol #3 tablet from the
20 Pyxis system for this patient; however, Respondent failed to document the administration of any
21 portion of the Tylenol #3 in the patient's medication administration record or otherwise account
22 for the disposition of the drug in any hospital record.

23 rr. On March 1, 2008, at 1002 hours, Respondent withdrew 1 Tylenol #3 tablet from the
24 Pyxis system for this patient; however, Respondent failed to document the administration of any
25 portion of the Tylenol #3 in the patient's medication administration record or otherwise account
26 for the disposition of the drug in any hospital record.

27 ///

28 ///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 673563, issued to Clara C. Williams;
2. Ordering Clara C. Williams to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,
3. Taking such other and further action as deemed necessary and proper.

DATED: _____

3/16/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer

Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2010102480
10649572.doc